

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

21901
File No. _____
Registered No. 152
St. _____ Ward _____

1. PLACE OF DEATH

County Boone Registration District No. 73
Township Columbia Primary Registration District No. 3006
City _____ (No. _____)

2. FULL NAME

(a) Residence No. 503 Worley St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Albert Byers

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-30-1907

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
23 6 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER Wm R. Wright

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Barrie Walburn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

14. INFORMANT Albert Byers
(Address) Columbia Mo

15. FILED 8/2/32 Beatrice Trubbe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 31 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 1930 to 7-31-30, 1930 and that I last saw her alive on 7-27-30, 1930, and that death occurred, on the date stated above, at 1145 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis
12 3/4 (duration) yrs. mos. ds.
12 3/4 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Suggestion from Obstruction bowels (duration) yrs. mos. ds. 10

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF July 31

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS (Signed) Stephen Deunk M. D.

1930 (Address) Columbia Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Columbia Cemetery Columbia Mo DATE OF BURIAL 8-2-1930

20. UNDERTAKER W. J. W. Anderson ADDRESS Columbia Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 26 1930

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A. B.--Every in

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

L. D. Brown with

1. PLACE OF DEATH

County Boone
Township
City Columbia

Registration District No. 73
Primary Registration District No. 2006

File No.
Registered No. 136
St. Ward)

2. FULL NAME

Marie Martha Byers

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 30 - 1907

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

FILED 9-10-1930

Beatrice Grubbs
by a Selby REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) July 31 1930

17. I HEREBY CERTIFY that I attended deceased from that I last saw h. alive on 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

Peritonitis
CONTRIBUTORY (SECONDARY) Infection from obstruction bowels - caused by adhesion from old appendectomy.
18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. ds.
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) 11802 M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

SUPPLEMENTARY

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE FEES FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-21901